# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

**Transmittal 334** | **Date: October 25, 2004**

**CHANGE REQUEST 3555**


**SUBJECT: Payment of Beneficiary Submitted Flu Claims and Flu Claims Submitted by Non-Enrolled Providers**

**I. SUMMARY OF CHANGES:** This CR provides instructions for carriers on the payment of beneficiary and provider submitted flu claims for services provided by non-enrolled providers. This causes claims processing problems when the service has been rendered by a provider who is not enrolled with Medicare. This CR directs carriers on how to process and pay for flu claims rendered by non-enrolled providers.

This transmittal provides business requirements to instruct carriers to post a pre-filled version of the CMS Form 1490S on their websites for claims for flu shots provided by non-enrolled providers.

**NEW/REVISED MATERIAL - EFFECTIVE DATE*: For claims with dates of service on or after August 1, 2003 through May 31, 2005**
**IMPLEMENTATION DATE: November 26, 2004**

***Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)**
**(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| N/A | |
| | |
| | |

**III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.**

## IV. ATTACHMENTS:

| | |
|---|---|
| **X** | **Business Requirements** |
| | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Notification** |
| | **Recurring Update Notification** |

***Unless otherwise specified, the effective date is the date of service.**

# Attachment - Business Requirements

| **Pub. 100-04** | **Transmittal: 334** | **Date: October 25, 2004** | **Change Request 3555** |
|---|---|---|---|

**SUBJECT: Payment of Beneficiary Submitted Flu Claims and Flu Claims Submitted by Non-Enrolled Providers**

## I. GENERAL INFORMATION

**A. Background:** Medicare providers are generally required to submit claims for beneficiaries. However, every year some claims are received directly from beneficiaries for flu shots from non-enrolled providers. In addition, some non-enrolled providers also submit claims for beneficiaries. Problems with claims processing occurs when the service has been rendered by a provider who is not enrolled with the Medicare program. In order to increase access to flu shots for Medicare beneficiaries, Medicare will accept, process and pay for flu shots provided to beneficiaries by non-enrolled providers, including opt-out providers.

**B. Policy:** Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. However, in some instances this does not occur. Carriers will reimburse beneficiaries for flu shots administered by non-enrolled providers, regardless of whether the claim is submitted by the beneficiary or provider. Questions and answers regarding payment of beneficiary submitted flu claims have been posted on the Medicare.gov Web site.

**C. Provider Education:** None.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*
*"Should" denotes an optional requirement*

| **Requirement Number** | **Requirements** | **Responsibility ("X" indicates the columns that apply)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Shared System Maintainers | | | | Other |
| | | FI | RHHI | Carrier | DMERC | FISS | MCS | VMS | CWF | |
| 3555.1 | Carriers shall post on their beneficiary Web site the attached pre-filled Form CMS-1490S for beneficiaries to download. | | | X | | | | | | |

## III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: N/A

| X-Ref Requirement # | Instructions |
|---|---|
| | |

### B. Design Considerations: N/A

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

### C. Interfaces: N/A

### D. Contractor Financial Reporting /Workload Impact: N/A

### E. Dependencies: N/A

### F. Testing Considerations: N/A

## IV. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date*:** For claims with dates of service on or after August 1, 2003 through May 31, 2005.<br><br>**Implementation Date:** November 26, 2004<br><br>**Pre-Implementation Contact(s):** Leslie Trazzi, (410) 786-7544<br><br>**Post-Implementation Contact(s):** Appropriate Regional Office | **Medicare contractors shall implement these instructions within their current operating budgets.** |

*__Unless otherwise specified, the effective date is the date of service.__

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

FORM APPROVED
OMB NO 0938-0008

# PATIENT'S REQUEST FOR MEDICAL PAYMENT

**IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS**

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

**1** Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

**SEND COMPLETED FORM TO:**
Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

**2** Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

**3** Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐

(Street or P.O. Box - Include Apartment Number)

(City) (State) (Zip)

**3b** Telephone Number
(Include Area Code)
( _ _ _ )
_ _ _ - _ _ _ _

**4** Describe the illness or injury for which patient received treatment

Flu Shot (90658/G0008)
Attach receipt from the doctor or provider that gave you the flu shot.
The receipt should include their name, address, date of flu shot, and amount you paid.

**4b** Condition was related to:

A. Patient's employment
☐ Yes ☐ No

B. Accident
☐ Auto ☐ Other

**4c** Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

**5**

a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholder's Name:

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

**6** I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

**6b** Date signed

**IMPORTANT**
**ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM**

## HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim.

### FOLLOW THESE INSTRUCTIONS CAREFULLY:

**A. Completion of this form.**

Block 1. Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in **Block 6** too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in **Block 6**. You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

**B. Each itemized bill MUST show all of the following information:**

- Date of each serv
- Place of each serv

| Doctor's Office | Independent Laboratory | Outpatient H |
|---|---|---|
| Nursing Home | Patient's Home | Inpatient H |

- Description of each surgical or medical service or supply furnish
- Charge for EACH serv
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTA THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed **Block 4** of this fo
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare cla
- If the patient is deceased, please contact your Social Security office for instructions on how to file a cla
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

### COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form,please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.